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H. R. 1989

To provide for medical injury compensation reform for health care services furnished using funds provided under certain Federal programs or under group health plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 5, 1993

Mr. MCMILLAN (for himself, Mr. TAYLOR of North Carolina, Mr. SANTORUM, Mr. DELAY, Mr. GINGRICH, Mr. HASTERT, Mr. HOBSON, Mr. KASICH, Mr. KOLBE, Mr. PAXON, Mrs. ROUKEMA, Mr. WALKER, Mr. BALLENGER, Mr. BLILEY, Mr. DREIER, Mr. GOSS, Mr. GRANDY, Mr. SOLOMON, Mr. CASTLE, Mr. SUNDQUIST, and Mr. SAM JOHNSON of Texas) introduced the following bill; which was referred jointly to the Committees on the Judiciary, Ways and Means, and Energy and Commerce

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A BILL

To provide for medical injury compensation reform for health care services furnished using funds provided under certain Federal programs or under group health plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Injury Compensation Fairness Act of 1993''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) health care expenditures are escalating beyond the ability of Americans to afford them, having increased from 5.9 percent of gross national product in 1965 to over 12 percent in 1990;

(2) the medical injury compensation system currently in effect in the United States is ineffectual in compensating injured persons, has very high administrative costs, and contributes to the high level of unnecessary spending on health care;

(3) as many as 15 out of 16 persons injured due to medical negligence never get compensation through the current medical malpractice system;

(4) malpractice insurance premiums, only 40 percent of which ever reach injured persons as compensation for their injuries, increased at an average rate of 18.3 percent per year from 1982 to 1988;

(5) unnecessary defensive medical practices, rendered by physicians in anticipation of juries' retrospective application of poorly specified standards of care to their diagnostic and treatment choices, add billions of dollars to the Nation's health care bill;

(6) the law governing medical malpractice operates to limit access to health care by driving costs

to unaffordable levels and by discouraging physicians from treating high-risk patients and from practicing in high-risk areas and specialties; and

(7) the Federal Government, which directly finances about 30 percent of the health care consumed in the United States and subsidizes a substantial portion of private health insurance, has a legitimate financial interest in addressing the problems associated with the current medical malpractice system.

(b) PURPOSE.—It is the purpose of this Act to—

(1) encourage the efficient resolution of medical injury claims, using alternative methods of dispute resolution;

(2) ensure fairness in the awards granted in medical injury cases;

(3) reduce inappropriate, unnecessary or defensive medical practices;

(4) reduce public and private health care costs;

(5) improve access to health care; and

(6) facilitate informed, responsible choices in the selection of alternative methods of dispute resolution and in the specification of appropriate standards for medical practice.

SEC. 3. MANDATORY RESOLUTION OF CLAIMS THROUGH CERTIFIED DISPUTE RESOLUTION SYSTEMS.

(a) APPLICATION TO CLAIMS ARISING FROM SERVICES FINANCED THROUGH CERTAIN FEDERAL PROGRAMS.—

(1) IN GENERAL.—Each individual or entity providing or receiving health care services for which payment may be made in whole or in part with funds provided under a Federal program described in paragraph (2) shall be deemed to have entered into an agreement—

(A) to resolve any medical malpractice liability claim arising from the provision of (or failure to provide) such services through a State dispute resolution system that is certified by the Secretary under section 4(b) (or the alternative Federal ADR system applicable under section 4(c)); and

(B) to bring any medical malpractice liability action that arises from a claim resolved through such a system only in accordance with the procedures described in section 5.

(2) FEDERAL PROGRAMS DESCRIBED.—The Federal programs described in this paragraph are as follows:

(A) The health insurance program under title XVIII of the Social Security Act.

(B) A State plan for medical assistance under title XIX of the Social Security Act.

(C) The health benefit program for Federal employees under chapter 89 of title 5, United States Code.

(D) Any program for the provision of hospital care and medical services by the Department of Veterans Affairs under chapter 17 of title 38, United States Code.

(E) A program for the provision of services at facilities of the Indian Health Service or at other facilities under the Indian Health Care Improvement Act.

(F) The program authorized under sections 1079 and 1086 of title 10, United States Code.

(G) The program for providing medical care at facilities of the uniformed services under title 10, United States Code.

(b) APPLICATION TO SERVICES FURNISHED UNDER EMPLOYER-SPONSORED HEALTH PLANS.—

(1) RESTRICTION ON DEDUCTIBILITY OF BUSINESS EXPENSES.—Section 162 of the Internal Revenue Code of 1986 is amended—

(A) by redesignating subsection (m) as subsection (n); and

(B) by inserting after subsection (l) the following new subsection:

''(m) CONDITIONING DEDUCTIBILITY OF HEALTH INSURANCE EXPENSES ON APPLICATION OF ALTERNATIVE DISPUTE RESOLUTION PROCEDURES.—Notwithstanding any other provision of this Code, no deduction may be taken under this section (including a deduction taken under subsection (l)) for expenses paid for insurance which constitutes medical care unless there is in effect an agreement described in section 3(a) of the Medical Injury Compensation Fairness Act of 1993 with respect to the resolution of medical malpractice claims arising from the provision of (or failure to provide) such medical care.''.

(2) REQUIREMENT FOR EXEMPTION FROM EXCISE TAX FOR NONCONFORMING PLANS OF TAX-EXEMPT ORGANIZATIONS.—Section 5000(c) of the Internal Revenue Code of 1986 is amended by striking the period at the end and inserting the following: '', or (in the case of an employee or an employer organization exempt from taxation under subtitle A) does

not have in effect an agreement described in section 3(a) of the Medical Injury Compensation Fairness Act of 1993 with respect to the resolution of medical malpractice claims arising from the provision of (or failure to provide) items and services for which payment may be made under the plan.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 1994.

(c) WAIVER OF AGREEMENTS NOT PERMITTED.—An individual or entity may not waive an agreement referred to in subsection (a) and may seek the enforcement of the agreement in any court of competent jurisdiction.

SEC. 4. REQUIREMENTS FOR DISPUTE RESOLUTION PROGRAMS.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

(1) provides that the standards described in section 6 shall apply to all claims resolved under the system;

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in

exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dis-

pute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings a medical malpractice liability action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(b) CERTIFICATION OF STATE SYSTEMS.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1994), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of subsection (a) for the following calendar year.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of subsection (a).

(c) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1994, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (b) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (2), (6), and (7) of subsection (a) shall apply to claims brought under the system;

(B) claims brought under the system shall be heard and resolved by arbitrators appointed by the Secretary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

SEC. 5. STANDARDS FOR MEDICAL MALPRACTICE LIABILITY ACTIONS BROUGHT AFTER RESOLUTION UNDER ADR SYSTEM.

(a) NO ACTION PERMITTED UNTIL RESOLUTION OF CLAIM UNDER ADR SYSTEM.—

(1) IN GENERAL.—If a medical malpractice liability claim is subject to an agreement under section 3(a), no medical malpractice liability action that is based on the claim may be brought in any court until the claim is initially resolved under an alternative dispute resolution system in accordance with this Act.

(2) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of paragraph (1), an action is ''initially resolved'' under an alternative dispute resolution system if—

(A) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(B) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(b) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a claim under an alternative dispute resolution system described in section 4, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—No civil action arising from a claim that is subject to alternative dispute resolution under this Act may be brought unless the action is filed in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) MANDATORY PRE-TRIAL SETTLEMENT CONFERENCE.—

(A) IN GENERAL.—Before the beginning of the trial phase of any medical malpractice liability action arising from a claim that is subject to alternative dispute resolution under this Act, the parties shall attend a conference called by the court for purposes of determining whether grounds exist upon which the parties may negotiate a settlement for the action.

(B) REQUIRING PARTIES TO SUBMIT SETTLEMENT OFFERS.—At the conference called pursuant to subparagraph (A), each party to a medical malpractice liability action shall present an offer of settlement for the action.

(4) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(c) EFFECT OF ADR DECISION ON BURDEN OF PROOF IN SUBSEQUENT ACTION.—In any action arising from a claim that is subject to an agreement under section 3(a), the trier of fact shall uphold the decision made under

the previous alternative dispute resolution system with respect to the claim unless the party contesting the decision proves by a preponderance of the evidence that the decision was incorrect.

(d) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to subsection (b)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the plaintiff, the amount of damages awarded to the party under the action does not exceed the amount of

damages awarded to the party under the ADR system by at least 10 percent; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is not at least 10 percent less than the amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

(A) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(i) the ruling was procured by corruption, fraud, or undue means,

(ii) there was partiality or corruption under the system,

(iii) there was other misconduct under the system that materially prejudiced the party's rights, or

(iv) the ruling was based on an error of law;

(B) the party contesting the ruling made under the previous alternative dispute resolution system presents new evidence before the

trier of fact that was not available for presentation under the ADR system;

(C) the medical malpractice liability action raised a novel issue of law; or

(D) the court finds that the application of such paragraph to a party would constitute an undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(e) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of an action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (b)(1).

(f) APPLICABILITY OF STANDARDS.—The standards described in section 5 shall apply to any action arising from a claim that is subject to an agreement under section 3(a) in the same manner as such standards apply to the resolution of such claims.

SEC. 6. STANDARDS FOR THE RESOLUTION OF CLAIMS AND ACTIONS.

(a) APPLICABILITY.—This section shall apply with respect to medical malpractice liability claims for which an agreement described in section 3(a) is in effect.

(b) STATUTE OF LIMITATIONS.—

(1) IN GENERAL.—No claim may be brought after the expiration of the 2-year period that begins on the date the alleged injury that is the subject of the claim should reasonably have been discovered, but in no event after the expiration of the 4-year period that begins on the date the alleged injury occurred.

(2) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, no claim may be brought after the expiration of the 2-year period that begins on the date the alleged injury that is the subject of the action should reasonably have been discovered, but in no event after the date on which the minor attains 10 years of age.

(c) CALCULATION AND PAYMENT OF DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant and the members of the claimant's family for losses resulting from the injury

which is the subject of a claim may not exceed $250,000, regardless of the number of parties against whom the claim is brought or the number of claims brought with respect to the injury.

(2) TREATMENT OF PUNITIVE DAMAGES.—

(A) LIMITATION ON AMOUNT.—The total amount of punitive damages that may be imposed under a claim may not exceed twice the total of the damages awarded to the claimant and the members of the claimant's family.

(B) PAYMENTS TO STATE FOR MEDICAL QUALITY ASSURANCE ACTIVITIES.—

(i) IN GENERAL.—Any punitive damages imposed under a claim shall be paid to the State in which the claim is brought.

(ii) ACTIVITIES DESCRIBED.—A State shall use amount paid pursuant to clause (i) to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

(I) licensing or certifying health care professionals and health care providers in the State;

(II) operating alternative dispute resolution systems;

(III) carrying out public education programs relating to medical malpractice and the availability of alternative dispute resolution systems in the State; and

(IV) carrying out programs to reduce malpractice-related costs for retired providers or other providers volunteering to provide services in medically underserved areas.

(iii) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to clause (i) to supplement and not to replace amounts spent by the State for the activities described in clause (ii).

(3) PERIODIC PAYMENTS FOR FUTURE LOSSES.—If more than $100,000 in damages for expenses to be incurred in the future is awarded to the claimant, the party against whom the damages are awarded shall provide for payment for such damages on a periodic basis determined appropriate by the alternative dispute resolution system (based upon projections of when such expenses are likely to be in-

curred), unless it is determined that it is not in the claimant's best interests to receive payments for such damages on such a periodic basis.

(4) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

(A) IN GENERAL.—The total amount of damages received by a claimant shall be reduced (in accordance with subparagraph (B)) by any other payment that has been or will be made to compensate the claimant for the injury that was the subject of the claim, including payment under—

(i) Federal or State disability or sickness programs;

(ii) Federal, State, or private health insurance programs;

(iii) private disability insurance programs;

(iv) employer wage continuation programs; and

(v) any other source of payment intended to compensate the claim for such injury.

(B) AMOUNT OF REDUCTION.—The amount by which an award of damages to a

claimant shall be reduced under subparagraph (A) shall be—

(i) the total amount of any payments (other than such award) that have been made or that will be made to the claimant to compensate the claimant for the injury that was the subject of the claim; minus

(ii) the amount paid by the claimant (or by the spouse, parent, or legal guardian of the claimant) to secure the payments described in clause (i).

(d) LIMITATION ON ATTORNEY'S FEES.—If the claimant has entered into an agreement with the claimant's attorney to pay the attorney's fees on a contingency basis, the attorney's fees for the claim may not exceed—

(1) 25 percent of the first $150,000 of any award or settlement paid to the claimant; or

(2) 15 percent of any additional amounts paid to the claimant.

(e) JOINT AND SEVERAL LIABILITY.—The liability of each party against whom a claim is filed shall be several only and shall not be joint, and each party shall be liable only for the amount of damages allocated to the party in direct proportion to the party's percentage of responsibility (as determined by the trier of fact).

(f) UNIFORM STANDARD FOR DETERMINING NEGLIGENCE.—A party against whom a claim is filed may not be found to have acted negligently unless the party's conduct at the time of providing the health care services that are the subject of the claim was not reasonable.

(g) APPLICATION OF MEDICAL PRACTICE GUIDELINES.—

(1) USE OF GUIDELINES AS AFFIRMATIVE DEFENSE.—In the resolution of any claim, it shall be a complete defense to any allegation that a party against whom the claim is filed was negligent that, in the provision of (or the failure to provide) the services that are the subject of the claim, the party followed the appropriate practice guideline.

(2) RESTRICTION ON GUIDELINES CONSIDERED APPROPRIATE.—

(A) GUIDELINES SANCTIONED BY SECRETARY.—For purposes of paragraph (1), a practice guideline may not be considered appropriate with respect to claims during a year unless the Secretary has sanctioned the use of the guideline for purposes of an affirmative defense to claims brought during the year in accordance with subparagraph (B) or (C).

(B) PROCESS FOR SANCTIONING GUIDELINES.—Not less frequently than October 1 of each year (beginning with 1994), the Secretary, shall review the practice guidelines and standards developed by the Administrator for Health Care Policy and Research pursuant to section 1142 of the Social Security Act, and shall sanction those guidelines which the Secretary considers appropriate for purposes of an affirmative defense to claims brought during the next calendar year as appropriate practice guidelines for purposes of paragraph (1).

(C) USE OF STATE GUIDELINES.—Upon the application of a State, the Secretary may sanction practice guidelines selected by the State for purposes of an affirmative defense to claims brought in the State as appropriate practice guidelines for purposes of paragraph (1) if the guidelines meet such requirements as the Secretary may impose.

(3) PROHIBITING APPLICATION OF FAILURE TO FOLLOW GUIDELINES AS PRIMA FACIE EVIDENCE OF NEGLIGENCE.—No claimant may be deemed to have presented prima facie evidence that a party against whom the claim is filed was negligent solely by show-

ing that the party failed to follow the appropriate practice guideline.

(h) SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.—

(1) IMPOSITION OF HIGHER STANDARD OF PROOF.—

(A) IN GENERAL.—In the case of a claim relating to services provided during labor or the delivery of a baby, if the party against whom the claim is filed did not previously treat the claimant for the pregnancy, the trier of fact may not find that the party committed malpractice and may not assess damages against the party unless the malpractice is proven by clear and convincing evidence.

(B) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subparagraph (A), a party shall be considered to have previously treated an individual for a pregnancy if the party is a member of a group practice whose members previously treated the claimant for the pregnancy or is providing services to the claimant during labor or the delivery of a baby pursuant to an agreement with another party.

(2) CLEAR AND CONVINCING EVIDENCE DEFINED.—In paragraph (1), the term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(i) PREEMPTION.—

(1) IN GENERAL.—This section supersedes any State law only to the extent that State law—

(A) permits the recovery of a greater amount of damages by a plaintiff;

(B) permits the collection of a greater amount of attorneys' fees by a plaintiff's attorney;

(C) establishes a longer period during which a medical malpractice liability claim may be initiated; or

(D) establishes a stricter standard for determining whether a defendant was negligent or for determining the liability of defendants de-

scribed in subsection (h) in actions described in such subsection.

(2) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in paragraph (1) shall be construed to—

(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(B) waive or affect any defense of sovereign immunity asserted by the United States;

(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(D) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

SEC. 7. DEFINITIONS.

As used in this Act:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution

system'' or ''ADR'' means a system established by a State that provides for the resolution of medical malpractice liability claims in a manner other than through medical malpractice liability actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice liability claim, or, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such a claim is alleged.

(3) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for losses for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide such services in the State.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the

State to engage in the delivery of such services in the State.

(6) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or claim.

(7) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a civil action (other than an action in which the plaintiff's sole allegation is an allegation of an intentional tort) brought in a State or Federal court against a health care provider or health care professional (regardless of the theory of liability on which the action is based) in which the plaintiff alleges a medical malpractice liability claim.

(8) MEDICAL MALPRACTICE LIABILITY CLAIM.—The term ''medical malpractice liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(9) MEDICAL PRODUCT.—The term ''medical product'' means a device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) or a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act).

(10) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(12) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 8. EFFECTIVE DATE.

This Act shall apply to claims accruing on or after January 1, 1994.

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